3. Rate setting methodology for case management for persons with chronic mental illness.

a. For the reimbursement periods beginning on or after April 1, 1999, providers will be reimbursed a statewide interim rate comprised of modeled costs for direct care plus a statewide weighted average for reported indirect costs. The modeled costs for direct care rate is based on cost calculations that include a statewide weighted average hourly wage for persons who provide case management as 100 percent of their job responsibilities, a predetermined caseload size, a statewide weighted average supervisory wage rate and span of control, and a statewide weighted average benefits factor. The associated indirect costs collected through the cost reporting process for administrative claiming include clerical and support costs, travel and training costs, and other allowable operating costs such as rent, utilities, office supplies, administration, and depreciation necessary to provide case management. Following each annual reimbursement period, each provider's actual allowable costs will be compared to interim reimbursement and any resulting monetary reconciliation will be made in accordance with item 6 of this section.

Total costs are projected from the historical reporting period to the interim rate period. Cost projections adjust the allowable historical costs for significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and efficiency, modification of federal or state regulations and statutes. Appropriate economic adjusters, as described in state regulations, are determined to calculate the projected expenses. The Implicit Price Deflator for Personal Consumption Expenditures (IPD-PCE), which is based on data from the U.S. Department of Commerce, is the most general measure of inflation and is applied to salaries and benefits, materials, supplies, and services.

Rates are adjusted if new legislation including the appropriations, regulations, or economic factors affect costs, as specified in state regulations. Cost data will be collected to supplement the cost report to capture costs not reported during the historical reporting period.

b. For the non-modeled component for the interim rates, provider costs by unit of service are arrayed from low to high. TDMHMR may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur. Statistical outliers (those providers whose unit costs exceed +/- two standard deviations of the mean) are removed. The mean projected total cost per unit of service is calculated after statistical outliers have been removed and this becomes the recommended reimbursement rate.

4. Reimbursement setting authority. The operating agency determines reimbursement rates after consideration of financial data, statistical information and public testimony. The Single State Medicaid agency has final approval of the reimbursement

5. Reviews of cost report disallowances. A contracted provider may request notification of the exclusions and adjustments to reported expenses made during either desk reviews or onsite audits, according to state regulations. Contracted providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by the operating agency or its designee under state law.

6. If a provider's costs exceed the statewide rate, TDMHMR, the operating agency, will reimburse the provider its costs up to 125 percent of the statewide rate. If a provider's costs are less than 95 percent of the statewide rate, the provider will pay TDMHMR, the operating agency, the difference between the provider's costs and 95 percent of the statewide rate.

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SUPERSEDES: NONE - NEW PAGE

22. Case Management for individuals with mental retardation or a related condition.

Reimbursement for case management services for individuals with mental retardation or a related condition is subject to the specifications, conditions, and limitations required by the operating agency or its designee. These include the specifications provided in OMB Circular A-87 and A-102.

The statewide reimbursement rates for this case management services program are interim throughout the rate period and subsequently adjusted to cost. The operating agency or its designee determines statewide reimbursement rates at least annually, but may determine them more often if deemed necessary. The reimbursement rates are based upon allowable costs, as specified by the operating agency or its designee, for qualified staff, travel, facility, and administrative overhead expenditures. The unit of service is one face- to-face contact per month.

Claims for reimbursement for case management services include:

- date of service;
- name of recipient;
- identifying Medicaid number;
- address
- name of provider agency;
- unit(s) of service delivered; and
- place of service.

Reimbursement rates are determined in the following manner:

1. Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost report for administrative claiming. All references to cost reports are the cost reporting process for administrative claiming. Failure to do so may result in penalties.
2. Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs, programmatic indirect costs, and general and administrative overhead costs.

a. Case management is an activity performed by a qualified case manager employed by the provider agency, with the person served to assess needs, and locate, coordinate and monitor necessary services. A rate is set for services provided to individuals in the mental retardation priority population.

b. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program. Providers must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.

3. Rate setting methodology for case management for persons with mental retardation.

a. For the reimbursement periods beginning on or after April 1, 1999, providers will be reimbursed a statewide interim rate comprised of modeled costs for direct care plus a statewide weighted average for reported indirect costs. The modeled costs for direct care rate is based on cost calculations that include a statewide weighted average hourly wage for persons who provide case management as 100 percent of their job responsibilities, a predetermined caseload size, a statewide weighted average supervisory wage rate and span of control, and a statewide weighted average benefits factor. The associated indirect costs collected through the cost reporting process for administrative claiming include clerical and support costs, travel and training costs, and other allowable operating costs such as rent, utilities, office supplies, administration, and depreciation necessary to provide case management. Following each annual reimbursement period, each provider's actual allowable costs will be compared to interim reimbursement and any resulting monetary reconciliation will be made in accordance with item 6 of this section.

Total costs are projected from the historical reporting period to the interim rate period. Cost projections adjust the allowable historical costs for significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and efficiency, modification of federal or state regulations and statutes. Appropriate economic adjusters, as described in state regulations, are determined to calculate the projected expenses. The Implicit Price Deflator for Personal Consumption Expenditures (IPD-PCE), which is based on data from the U.S. Department of Commerce, is the most general measure of inflation and is applied to salaries and benefits, materials, supplies, and services.

Rates are adjusted if new legislation including the appropriations, regulations, or economic factors affect costs, as specified in state regulations. Cost data will be collected to supplement the cost report to capture costs not reported during the historical reporting period.

b. For the non-modeled component for the interim rates, provider costs by unit of service are arrayed from low to high. TDMHMR may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur. Statistical outliers (those providers whose unit costs exceed +/- two standard deviations of the mean) are removed. The mean projected total cost per unit of service is calculated after statistical outliers have been removed and this becomes the recommended reimbursement rate.

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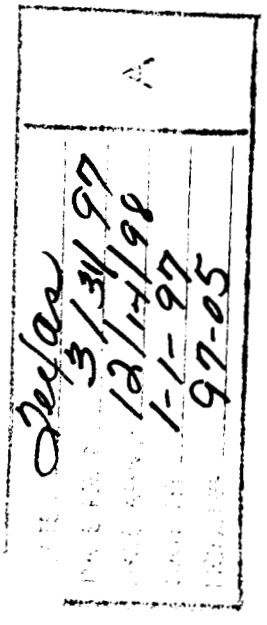
4. Reimbursement setting authority. The operating agency determines reimbursement rates after consideration of financial data, statistical information and public testimony. The Single State Medicaid agency has final approval of the reimbursement

5. Reviews of cost report disallowances. A contracted provider may request notification of the exclusions and adjustments to reported expenses made during either desk reviews or onsite audits, according to state regulations. Contracted providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by the operating agency or its designee under state law.

6. If a provider's costs exceed the statewide rate, TDMHMR, the operating agency, will reimburse the provider its costs up to 125 percent of the statewide rate. If a provider's costs are less than 95 percent of the statewide rate, the provider will pay TDMHMR, the operating agency, the difference between the provider's costs and 95 percent of the statewide rate.

24. Rate-Setting Methodology for ICF/MR Dental Services

Reimbursement for comprehensive dental diagnostic and treatment services, as described in Item 15b of Appendix 1 to Attachment 3.1-A and Item 15b of Appendix 1 to Attachment 3.1-B. TDH reimburses enrolled dental providers for authorized and allowable dental services provided to ICF/MR consumers. Providers of dental services must be enrolled with TDH and accept, as payment in full, TDH's reimbursement. Reimbursement is made for four categories of service: Emergency, Preventive, Therapeutic, and Orthodontic. Emergency dental services for ICF/MR consumers are reimbursed exclusively under the above mentioned Emergency Service Category. Payment for dental services will be the lowest of: (a) the provider's usual fee; (b) the maximum fee listed on the program fee schedule (derived from the State's Texas Health Steps fee schedule); (c) the adjusted, authorized fee.



SUPERSEDES: TN - 89-15

25. Prosthetic Devices - In-home Services for Total Parenteral Hyperalimentation

The single state agency or its designee reimburses each provider on a monthly basis. Reimbursement is based on one-twelfth of the maximum yearly fee established by the single state agency or its designee. The single state agency or its designee will adjust the allowable fees or rates each state fiscal year by applying the projected rate of change of the implicit price deflator for personal consumption expenditures (IPD-PCE). The single state agency or its designee uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to the single state agency or its designee at the time rates are prepared. The first adjustment will be effective January 1, 1993, at the maximum yearly fee of $53,000 or $145 per day. There will be no adjustment for 1994 and thereafter. The single state agency or its designee does not reimburse more than a one-week supply of solutions and additives if the solutions and additives are shipped and not used because of the recipient's loss of eligibility, change in treatment, or inpatient hospitalization. The provider must exclude from its monthly billing any days that the recipient is an inpatient in a hospital or other medical facility or institution. Payment for partial months will be prorated based upon actual days of administration. Hospital outpatient departments furnishing in-home total parenteral nutrition must be separately enrolled as a provider of in-home parenteral hyperalimentation. Reimbursement to hospital outpatient departments furnishing in-home total parenteral nutrition may not exceed the maximum yearly fee established by the single state agency or its designee.

13.a. Diagnostic Services for Persons with a Potential of Mental Retardation

Not Provided

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27. Rate Determination for Rehabilitative Services.

The operating agency will reimburse qualified providers for rehabilitative services provided to Medicaid eligible persons with mental illness.

1. Reimbursement during Initial Reimbursement period.

(a) For the initial reimbursement period, beginning January 1, 1997, and ending August 31, 1998, providers will be reimbursed utilizing estimated costs to determine pro forma rates for the following categories of rehabilitative services:

(1) Individual community support services provided by a professional (unit of service - 30 minutes)

(2) Individual community support services provided by a paraprofessional (unit of service - 30 minutes)

(3) Group community support services provided by a professional (unit of service - 30 minutes)

(4) Group community support services provided by a paraprofessional (unit of service - 30 minutes)

(5) Day programs for acute needs (adult) - (unit of service - 1 hour)

(6) Day programs for acute needs (children) - (unit of service - 1 hour)

(7) Day programs for skills training (adult) - (unit of service - 1 hour)

(8) Day programs for skills training (children) - (unit of service - 1 hour)

(9) Day programs for skills maintenance - (unit of service - 1 hour)

(10) Plan of Care Oversight (unit of service - 1 contact)

SUPERSEDES: TN • ~~93-16~~

STATE TX DATE R 8-15-96 DATE M 4-1-98 DATE EF 1-1-97 NUMBER 96-15	A